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ABSTRACT

Described is an infant consultation service which provides preventive psychiatric intervention to the families of young children, training of professionals and paraprofessionals, and a research component. Reviewed are clinic experiences leading to the program and the underlying theory which stresses integration of familial and individual development. Described are varieties of counseling services offered such as group meetings for parents, intensive guidance in the mother-child relationship, and group meetings for both parents and children. It is noted that volunteer professional social workers needed training in areas such as understanding of family interactions and dynamic processes. Also explained is the training program for paraprofessionals, most of whom were selected from parents who had successfully completed a therapeutic program. It is reported that the previous patients experienced emotional difficulties during the training program and were not utilized as paraprofessionals. Aspects of the research component are considered including followup interviews of clients. Program evaluation is given to indicate that the Infant Consultation Service has led to 52 percent of cases receiving additional services suggesting that the service provides early intervention which may well prevent more serious problems later. (DB)

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Preventative Interventions For The Very Yo

An Infant Consultation Service Interweaves Service, Trai

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Having decided, in 1970, to establish a small counseling service for parents of infants and toddlers, we soon discovered that we were into something more complex than we had expected. In the first section of this paper we will review thos complexities both through some brief history and in relation to some of our theorizing. In the later sections we will discuss specific functions of the service, issues of training and, finally, assessment and research.

Looking Backward

The idea of a counseling service for parents of infants and toddlers flowed naturally from long experience (14 years) with a therapeutic nursery school in our child psychiatry department. Most of our staff had learned a great deal about disturbances in very young children and their parents, as well as about the dynamics of family life at that developmental phase. Having

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We found that these family interviews could be very productive. Also, through that medium we had an opportunity for directly observing how subtle but powerful and long-lasting, mutually maladaptive transactions between certain parents and their very young children evolve.

An important department-wide activity became the weekly demonstration interviews in which most of the staff observed the chief of the department interview families with preschool children. These interviews, observed through the one-way window, were (and continue to be) followed by intensive discussion of what had been seen and listened to by everyone. Many of these interviews were videotaped so there was opportunity for those with special interest to review the interviews more than once. Those on the staff with interest in the problems of parents and very young children developed special clinical acumen in this area. Refinement of diagnostic thinking about the problems in this phase of development, and therapeutic techniques for helping parents through a brief series of family interviews evolved.

Alongside of our experiences with preschoolers in the therapeutic nursery school and in family group interviews, was our coincidental interest in group therapy. Many staff members became impressed with the effectiveness of dynamic group process for helping troubled parents. We observed that group sharing of problems and anxieties common to parenting has a relieving impact on most parents. We believe, however, that for

sharing to be meaningful beyond immediate emotional ventilation, sensitive and wise leadership based upon clinical knowledge about early family experience is essential.

Just a little more history. Anticipating changes in our clinical programs that we thought might arrive with the development of a community mental health center, our department had experimented with the use of brief, time-limited group approaches with parents of children of all ages. The service had taken shape in which families applying for help were offered an initial family interview, followed by six parents group meetings, followed by a follow-up family or parent meeting. This format became a reliable one as a basis for providing first phase help. We found in follow-up evaluations[3] that a surprising number of parents felt this brief series of clinical contacts had been very helpful to them even though the behavioral symptoms in their children had not necessarily ended. Their own objectivity and tolerance as parents seemed to have grown as a result of the group experiences.

Theory

We will briefly outline some of the theory that integrates our project. Clinical work with children requires a <u>developmental</u> frame of reference. Because of the ways in which we have worked with parents and children our theoretical perspective has come to include the notion of <u>familial development</u> in addition to and interlaced with <u>individual development</u>. This notion, which places the individual child's development in the context of an evolving or changing <u>family system</u> adds considerable complexity to clinical thinking. One way in which we have come to think about the family

derives from sociologic theory about social systems and the concept of resistance to change. Some of us have found it useful to view any family as a system undergoing a constant series of developmental changes. Most developmental changes in families evolve fairly smoothly and constructively. Some meet enormous resistance, a perspective introduced in an earlier paper by Brown.[4] Using the notion of resistance to change in a family system, one can try to discern how troubles and clinical symptoms result from failure to master normal developmental stresses and changes evolving in the life of the family. Extending this just a little further, we note that resistance to developmental change might arise from various sources. An example illustrates this. A mother finds it difficult to let her baby crawl on the floor. This, then, is a mother's resistance to spontaneous individual developmental change in her baby. The mother's failure to facilitate normal developmental progress in her child may very quickly contaminate the normal development of the whole family unit. The child is blocked from experiences which foster the development of competencies and facilitate its evolution as an emerging autonomous little person. The mother herself, in avoiding the anxiety her child's new behavior challenges her to face, fails to move forward in her role function and in her individual maturing as a mother. Coincidentally the father also fails to make progress in his role as parent responding to an energetic, curious, exploratory, little child. In a sense, everyone stops growing and we would say that in accepting this in each other the family as a system is resisting normal change. These

events may become nuclei for subsequent pathologic relating in the family and for individual disturbances in the children.

Left out of this example are the infinite number of possible causative factors that may have produced mother's resistance to her child's development. These may include not only her own psychodynamics, but her husband's, the nature of the marital relationship, and purely environmental issues as well - - the dwelling they live in, the presence of danger, physical limitations, etc. All this alludes to more than we can review in this presentation. The main point, in summary, is that the theoretical framework that guides our work with parents of very young children takes very seriously the issues of intrafamilial dynamics and mutual adaptation as well as the view of families as evolving systems. We believe that this kind of theoretical formulation keeps us open to pragmatic approaches to each family problem and prevents over-investment in traditional approaches when they are not applicable. It is especially useful for organizing our approach to preventive mental health.

Early prevention requires, in our estimation, and holistic view of development. The measures we as clinicians can use for early prevention include purely educative guidance for parents, along with psychodynamic therapeutic interventions, group process, and environmental alterations. Recommending appropriately for the latter requires that we engage in a vital way with other child care and nursery school settings, community agencies and with currents in the surrounding social system. If our thinking includes a focus upon the resistances to and interferences with developmental change in families, we may be able also to more clearly define what kinds of helpers need to be

trained and what kinds of social agencies are needed for meeting particular kinds of failures.

Functions Of The Infant And Toddler Counseling Service For Parents

We have already described the basic service model of family and parent group interviews. We began our service by publicizing it through established channels. We notified all of the pediatric attending staff of the medical center. A sizeable number of pediatricians showed interest but in fact, relatively few of them referred parents to the service. A newspaper article about a research project in our department called the "Parenting Project" produced numerous phone calls from young parents who were attracted by the idea of a research program for "normal families." We learned from these experiences to emphasize the theme of normalcy in our publicity and also to look for referral elsewhere than from pediatric sources.

Usually the group meetings are attended by mothers. Fathers participation varies considerably.

At the end of six group meetings, certain parents have elected to go through another series of six. Some husbands have accepted referral to a series of married couples group meetings which are limited to six sessions. Other families have been referred into another service in our department in which 5 or 6 families, including the child, meet together weekly for 12 sessions. These "family education workshops" are lead by educational therapists from our nursery school. A number of mothers in the groups have been seen to need a period of

intensive guidance in the mother-child relationship. We refer them into still another service in which mother and toddler or infant are seen together for a series of sessions. In summary, the parent groups provide a central clinical process leading to the desired constructive changes or to a clarification of the parent's and child's problems. On this basis a family can spin off into other, differentiated services as they seem indicated. Our objectives in the group process are the following:

1. To encourage the sharing of problems and the search for solutions to those problems among group members.
2. To stimulate an approach to problem-solving that involves an examination of one's own and one's children's behavior in order to discover the meaning in it.
3. To invite some self-examination and awareness of childhood as significant in determining present relationships within the family.

The problems introduced by parents in the groups include:

1. Ordinary parental worries about eating, sleeping, walking, talking, toileting, and socializing, problems with siblings.
2. Major concerns about such items as rejection of food, feces withholding, failure to verbalize, resistance to sleeping, aggressivity, and poor frustration tolerance.
3. Marital tensions; conflicts with grandparents (in-laws); maternal post partum depression; maternal feelings of isolation and communication problems with pediatricians.

Issues Of Training

We referred earlier to "complexities" in the development of the service and to "issues of training." We will discuss the issues of training in two sections: A. Training of Professional Social Work Volunteers and B. Training of Paraprofessionals.

A. Training Of Professionals (Volunteers)

Soon after the service began it became clear that the available Child Psychiatry staff time was not sufficient to meet the program's needs. A call for volunteers from non-working mental health professionals who were known to the initiator of the project (Helen Reid) was successful. A number of capable individuals, most of them holding Master's degrees in psychiatric social work, offered from one half to one day per week. None, however, had more than minimal experience in clinical work with very young children and parents. The volunteering professionals were mostly mothers of preschool or early school children who had taken leave from their careers as social workers because of maternity. The length of their professional inactivity varied, and the area of their specialization in the field of social work was diverse. They all showed a marked interest in a project dealing with families of young children. We speculate that a common motivation for involvement in this particular project comes from an interest in understanding and being helpful to clients in a similar phase of parenthood.

A brief initial operating period pointed out that most of the professionals were not familiar with the information involved in early family interventions, namely, knowledge of a) family interaction, b) the psychology of early childhood development, and c) brief intervention techniques. Thus, a phase of training was necessary to equip them with the basic specialized theoretical and factual knowledge, and technical intervention tools.

The training schedule established included the following traditional steps:

1. Demonstration by an expert family therapist of interviews of families including children under 3 years of age, as a basis for discussion of technical problems and understanding of family dynamics.
2. Series of lectures and discussions on early child development given by an experienced educational therapist.
3. Group supervision of brief family and group interventions conducted by the volunteer social work staff.

The results of this training program have not been rigorously controlled or quantified, although first steps in this direction will be described later in the paper. At this point, descriptive evaluation only is presented. On the whole, it appears that the professional staff gained skills and confidence in the type of interventions required by the service, and are now functioning within delineated objectives of the project. Nevertheless

qualitative differences among workers remain, and the gain from a relatively extensive period of training at times appears minimal. Two particular deficiencies should be stressed: a) inadequate understanding of family interactions and underlying dynamic processes often is evidenced, and b) mechanisms of unconscious identification of the therapist with one member of the family group, usually the patient-child, led to distortions of interaction.

These essential restrictions to the success of training may involve several factors. First, it is reasonable to question whether therapeutic abilities can be taught by conventional means, such as the ones described above, observations, classes, supervision, or whether attention should be given to a different type of training, involving a personal therapeutic experience. Second, it is possible that the particular characteristics of this group of social workers, namely their situation as mothers of young children, constituted a negative factor in handling problems encountered by young families by over-facilitating processes of unconscious identification. Our experience does let us conclude that prior traditional social work training associated with earning the academic Master's degree, does not provide an adequate foundation for specialized work involving families of very young children.

B. Training Program For The Paraprofessional Staff

The paraprofessionals were chosen as candidates for the

specialized training program from parents of former patients in the Section of Child Psychiatry's therapeutic nursery school. The selection criteria were: a) successful outcome of the therapeutic intervention for themselves and their family, b) desire to return the services received in the clinic to the community, c) interest in entering the field of the helping professions and in furthering their own formal education programs. It was felt that former patients of the clinic whose treatment involving problems with a pre-school child had a successful outcome, could be particularly appropriate candidates for training as counselors for families of young children.

Secondly, it seemed that a group of successful former patients would constitute an exploratory sample for the innovative implementation of a non-traditional form of training, combining in the same setting personal therapy and training of therapeutic skills.

Thus the hypotheses underlying the training of paraprofessionals were: a) former patients having successfully benefited by the treatment program in the clinic would be effective counselors in handling family problems, b) training including both a therapeutic and supervisory experience would be more effective than the traditional social work training.

Description Of The Paraprofessional Group

During the first year of operation, the paraprofessional group included eight members: Six female members were former mothers

of patients in the clinic and had received intensive and prolonged treatment for themselves and their families. All of them had one child who had been placed in the therapeutic nursery school and each mother had received individual treatment. Two members, one male and one female had not been patients of the clinic, and did not present a severe family disturbance. Both were and are still undergoing individual therapy. Both had been involved in individual psychotherapy for a period of time, and their psychotherapy was an ongoing experience as they participated in the other training and supervisory aspects of the program described below.

The group was organized as a therapy group in which the members could openly present their internal difficulties as well as explore their interrelationships. One important variation from a traditional group therapy was the addition of a training component. Each member was asked in turn to present a problem while the others acted as therapists. Two professional staff members functioned as supervising psychotherapists, intervening on two levels - therapeutically when the problems of the group were not handled effectively by the trainees, and didactically when the supervisor judged that examination and discussion of issues just illustrated, could effectively help the group members acquire therapeutic skills.

A flexible academic program was devised and included supervised observation of short-term mothers and couples groups, course on child development and participation as co-therapists with a

trained social worker in the handling of a short-term family or group intervention.

Outcome Of The Group

Quantitative measures of process and outcome are being devised, in part based on data elicited by experimental procedures applied as pre-tests to this group. However the results of the first year of operation are here presented and discussed descriptively.

The main outcome was a gradual elimination of the six former clinic patients as members of the group and exclusion of four of them from the paraprofessional program. Two women dropped out during the first few months by mutual decision of the therapists and themselves, and the remainder at the end of the year. The two members who were not connected with the clinic remain active members of the group, now in the process of reorganization. The difficulties presented by the former patients were in two areas:

1. The experience of training through psychotherapy appeared to produce a disintegrative personality process in the six former patients. The manifestations appeared to be intolerable anxiety or depression and/or heightened primitive mechanisms of defense. In the two members who were not former patients, a process of progressive insight of intrapsychic mechanisms and integration appears to have taken place and is still in progress.

2. Although there is still insufficient perspective and

experience of the effectiveness of the paraprofessionals in brief family and group interventions as co-therapists, it appears that the former patients manifested great difficulty in handling that function. A phenomenon of unconscious identification with the child against the mother as a recipient of the projected "malignant" mother-part of themselves seemed to occur, thus impeding the therapeutic exchange.

An attempt at understanding the factors contributing to this striking, unexpected outcome follows:

1. Training through psychotherapy involves a duality of roles. On the one hand, the trainee is a patient in the group, but on the other hand, he is also required to act as a therapist. This duality seems to induce a complicated relationship with the professional therapist, particularly in making a distinction between transference reactions and reality. This inherent ambiguity of the therapeutic training group might require the capacity to maintain a relatively intact observing ego function. It can be hypothesized that patients, like the members of this group who have presented severe disturbances manifested in early pathology in their child, do not possess a sufficiently organized personality to sustain the ambiguity of this experience.

2. The step from the status of former patient to the role of therapist might constitute a most difficult reversal of roles. The experience described above points out that former patients, in spite of an apparent recovery and the achievement of an

adequate level of parenting function, might undergo a profound regression when functioning as a trainee in a therapy group and/or a co-therapist of parents' groups.

Only tentative indications can be derived from the limited data from the two paraprofessionals who were not clinic patients. They seemed to be able to use the therapeutic training effectively, both to further their self-understanding and understanding of their group's interactional processes, and to apply such insight for a better grasp of the parent-client. Their work as co-therapists manifested qualities of accurate empathy and non-possessive understanding of the client. A great deal more experience is needed, however, to evaluate the positive aspects of this type of training, and compare the results with the outcome of a more traditional approach to the teaching of psychotherapeutic skills. The group is in the process of reorganization based on the knowledge acquired in the first year of operation.

Our training experiences to date suggest:

1. Selection of paraprofessionals for training in a therapeutic group should be done with caution. Former patients who had presented serious personal difficulties do not, despite the good results of their own therapy, appear to be promising candidates.

2. Insufficient data is available to support or invalidate the effectiveness of the non-traditional form of training through

psychotherapy. This method proved unsuccessful in the present sample, but this failure seems related to the particular composition of the group. The positive experience with two non-clinic patients and a positive trend emerging with some new members added in the last three months indicates the possible effectiveness of the technique for teaching psychotherapy.

3. Currently in the mental health field, budgetary considerations and a philosophical preference for emphasizing as basically helpful, the presence of an interested human combine to encourage increased use of paraprofessionals in clinical work.[5] However, the relationship between types of training of paraprofessionals and their effectiveness as therapists remains insufficiently studied. Thus we have added to the questions noted earlier in this paper, an interest in identifying dimensions of the ICS experience perceived as most helpful for clients, and an interest in tracing how participation in the training program relates to changes in the paraprofessional therapists' ability to deliver these helpful experiences.

Research Perspectives

The inclusion of a formal research component in a new clinical service and training program represents an extension of the method of self-observation and shared commentary illustrated by the weekly demonstration interview described earlier. We have had a continuing interest in assessing empirically what we do, in our training programs[1] and in our programs for serving clients[3].

The formal research aspects builds on the foundation idea of research, a commitment to observation and careful recording of observations. The formal research endeavor simply adds the further responsibility for explicitly relating the methodological operations and precedures to the ideas (programs) one seeks to evaluate and assuring that the methods of observation and data recording can be shared in a way which permits replicability by others, and a basis for judging the reliability of the data.

Let us now look at some of the questions generated by the ICS and how we are proceeding with research to help answer those questions.

The theory and practice of clinical service we have described, puts the person of the clinician in a central role. The clinician's formal knowledge, but certainly and importantly the perceptions and feelings experienced as the interviews flow along, provide the basis for on-the-spot decisions about how to respond. What is the response set a person brings into the clinical endeavor? Does clinical training and studied experience uniquely alter the well learned "basic disposition" so that a person, as clinician, can make available to another person, as client, some new idea or sense of emotional worth they can assimilate into themselves and take away for constructive use.

We approach measuring this by asking our trainees to participate vicariously in a real ICS family interview. A video tape interview done by the senior staff member developing the ICS program (Helen Reid) was video taped. The tape was shown to both professional and paraprofessional trainees (by now 26 have taken the precedure). At various points the tape was stopped and the observer was asked to respond to questions which could reveal their understanding of the parents, the child, the interactions between clients, the purpose of the clinician, how they themselves could feel it was appropriate to respond, etc. Sample questions to which the clients wrote open-ended responses were: a) In making her comment, what do you think the interviewer's intent was? b) If you were the interviewer, what would be your thinking about whether (and how) to intervene at this point? c) Imagine you are the interviewer. What feelings and thoughts might you be having about the parents' relationship to each other? d) How would you describe the emotional mood and feelings of the father? etc.

As a first step to using this material empirically, we asked the interviewing clinician to use herself as a standard and read and "score" the protocols of each of the 26 respondents. Because the procedure was being developed while people were already in training, we do not have, for the people being discussed in this paper, a neat set of protocols based on administrations of the precedure before any training (or ICS

experience took place) then followed by later readministrations to ascertain changes. If, as working hypothesis, we assume that the procedure taps, to some degree, a person's intrinsic sensitivity, perceptual-cognitive bias, and so forth, we might be able to use even these first collections of data to help understand why some of our first paraprofessional trainees decided by themselves, or had to be asked to leave the clinical phases of the program.

As Figure 1 illustrates, there is a large range of scores on the procedure from 34 to 110. Clearly the procedure, involving

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Insert Figure 1 about here

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future clinical interviewers as "vicarious interviewers," reflects unique tendencies and appears to be a promising relevant method for establishing differences between individuals. We note that 3 of the 6 paraprofessionals, who were former patients, indeed did score at the very lowest end of the distributions of scores. Considering that 6 of the participants out of a total of 26 were asked to leave, we can say that this group was highly over-represented in the lowest quartile of scores, and under-represented (there were none) in the highest quartile. Although we do not have the satisfaction of a "blind" judgment, there is reassuring support for the belief

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FIGURE 1

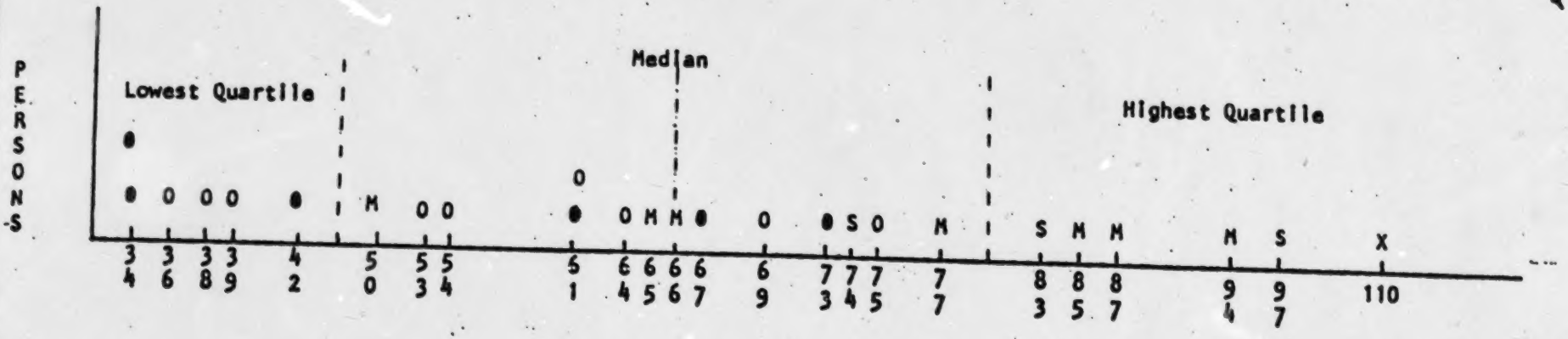
Congruance of Perception and Uncerstanding
of a Videotaped I.C.S. Family Interview

Scores of 26 Subjects

Range	34-110
Lowest quartile	34-42
Median:	65-5
Highest quartile:	83-110

Code

- ● = Former clinic patient
- O = Other paraprofessional
- M = M.S.W. returning to field
- S = Clinic staff member
- X = Senior clinician who did the video interview and scored all protocols - the "Standard"



that whoever is hiring our own department staff knows what he or she is doing. We have earlier emphasized the fact that Masters level social workers did not have an adequate backgound, on that basis alone, for making competent brief interventions for problems of families and young children. Nevertheless, schools training professional social workers could also take some satisfaction from the distribution of M's reported in Figure 1. The MSW background does appear to facilitate focusing on the important issues of a clinical transaction. Given the number in a sample, we can only report the observations in Figure 1 as a trend. Application of the appropriate statistical test (Kolmogrov-Smirnov one sample test) yielded a D of .25 which was not statistically significant.[7]

We have established that a standard procedure for sampling how trainees observe and conceptualize might well indeed serve as a discriminating indicator of the effect of training. By applying this procedure before training and after training to our next group of paraprofessional and social worker ICS volunteers, we will also be able to assess the degree to which a formal professional academic background might be necessary for the kind of brief clinical work our service chooses to do.

In the first year of operation of our program, 86 families had at least one face-to-face contact. Since the Infant Consultation Service was conceived as a preventative endeavor, and the

publicity emphasized our availability to families of young children. it is of interest to note that one-fourth of the children with reference to whom these 86 families contacted the ICS were less than 18 months of age, and only 9 of the 86 were older than age 4.

The basic service model, noted above, called for a family interview, a series of 6 group meetings of mothers, and a follow-up family interview. In the free exploration of our program, many variations from this theme occurred. For example, some families had a series of family interviews. For other families, the group was a Couples Group experience. Some families immediately asked for and were judged to be ready to benefit from an additional series of 6 group meetings (sometimes both a Couples Group and a Mothers Group experience being involved). Despite all of these variations, we decided as a first effort in follow-up, to ask the therapists who had run the initial Infant Consultation Service group to evaluate whether they judged the families they had served to have gotten maximal, neutral, or negative results from the procedure. These categories were defined as follows:

I. Would you say they had gotten much benefit from their ICS experience (i.e., improvement, problems and worries resolved, questions clarified, symptoms alleviated, etc.). In short, a very positive, good result.

II. Would you say their ICS participation had not provided any significant new perspective or strength to help them move ahead (i.e., although they may have had an interesting experience, their initial concern, problems, symptoms, etc. were essentially not significantly better, but neither were they necessarily worse). In short, a moderately positive or neutral outcome.

III. Their ICS participation had been an unhelpful experience (they seem, if anything, more confused with respect to their initial questions or worries, the problems they described at the end of the service seemed to be more severe or weigh on them more heavily than those described initially, the symptoms concerning them seemed, in quantity or severity, perhaps to have gotten worse). In short, a negative outcome.

The therapists, as judges, were asked before making their ratings to establish a frame of reference by thinking of all the families they had personally worked with, and also of other ICS families they had heard discussed which had been worked with by other therapists. They then were urged to keep in mind that the probable range of outcomes should be assumed to involve approximately 25% highly successful outcomes, 50% in category II and, 25% in category III. It was the researcher's initial expectation that some 20 families in the two extreme categories would be identified, assigned to follow-up interviewers (paraprofessionals now in training

who had not had contact with those families) and we would then have an "experiment" in which clients' own perceptions could be related to the groups defined by the original therapist. To our surprise, despite the "normal curve" of outcomes we alluded to, our therapists found only 5 cases they could identify as fitting III - - the negative outcome. Of course, the definitions of the three categories was such that a substantive base was available which logically would permit the therapists to deviate in judging their particular cases from what was presented as a probable overall distribution. As we shall see, the clients end up agreeing with the therapists.

We then designed a follow-up interview which explored via a telephone call the clients' recall of the experience, and evaluated outcome by means of 3 clusters of questions dealing with: 1) the area of the child's symptoms (improving?, new symptoms appearing since ICS?, old symptoms reoccuring?), 2) a parent cluster in which parents could indicate how they now worked together and what happened to mother (the informant) or her spouse's personality, and 3) a "referral" cluster in which their interest in returning to the service or making it known to friends was tapped.

Since only 5 catagory III cases were found, we ended up using the number of catagory I cases (22) as the definer of sample size, and selected at random 17 category II (neutral outcome)

cases, as well as the 5 category II cases to represent the other group. By using 5 different telephone interviewers, each of whom did a small number of cases, systematic follow-up interviewer bias was adequately delimited. Each follow-up interviewer received a like number of category I and category II (or III) cases, not knowing which was which.

Our follow-up sample was reduced by 7 when a sixth paraprofessional interviewer had to withdraw from the study, and at the last moment couldn't be replaced. In addition, we discovered how highly mobile our young population is. Three of the five category III cases, three of the 16 category II cases, and five of the 22 category I cases had moved, and no forwarding telephone number could be ascertained. An additional two category I cases were located but not available -- one mother having gotten seriously ill and being in the process of brain surgery, while another family had moved from California to Florida.

We thus ended up being able to follow up 13 cases judged by the original therapists as highly successful and 12 cases judged by the original therapists as having a neutral, or (2 of these cases) negative outcome. The follow-up interval for the successful cases ranged from 2 to 10 months since the end of the basic (first) ICS service with a median interval of 8 months. For the less successful group, the follow-up range was from 5 to 20 months, with the median interval 9.5 months. Overall we succeeded in following up 78% of the cases,

a little better than the usual experience in this kind of research effort. In discussing the results of this follow-up we wish to underline that many of the families were, indeed, "spun off" into additional services. 8 of the 13 category I cases had subsequent service (some of it continuing at the point of the follow-up). 5 of the 12 category II-III cases (actually none of the category III cases received additional service) had further work done in the clinic. Although the trend indicates that more category I cases sought and were offered additional service than was true for category II-III, the discrepancy in proportions is not significant when tested statistically (Chi square = .92, probability > .30). We'll return however to the implications of this trend in our comments below.

First let us turn to Table I. Based on the phone follow-up

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Insert Table I about here

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interviews, the outcome for the clients of the service were categorized as very positive, moderately positive, or negative. It is important to note that moderately positive means just that, and is not a "neutral" category as was the case for the judgments asked for the ICS therapist. Thus in Table I we can compare the degree of outcome described by the client in

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TABLE 1

Therapists and Clients (Mothers) View of the I.C.S.

Therapists Judgment*	Therapy outcome based on follow-up interviews: Very Positive	Moderately Positive	Negative
I N = 13	4 (30.8%)	7 (54.8%)	2 (15.4%)
II or III+ N=12	5 (42%)	4 (33%)	3 (25%)
Total N=25	9 (36%)	11 (44%)	5 (20%)

*I = Much benefit. Problems and worries resolved, questions clarified symptoms alleviated.

II = Participation had not provided any significant new perspective or strength. They may have had an interesting experience. Their initial concerns were not significantly better. In short, a moderately positive or neutral outcome.

III = I.C.S. an unhelpful experience. If anything they seemed more confused, symptoms seemed worse--a negative outcome.

\+ Two of the total of 5 cases judged III were successfully contacted. Both mothers described very positive outcomes.

relationship to a successful versus non-successful categorization based on therapist judgments. It is of interest to note that only 20% of our cases can be viewed, from the clients' point of view, as having not gotten something of worth from the ICS. 36% of the cases felt that the outcomes were very positive and their comments in the interview gave substantiating anecdotes for their judgments. Likewise, the 11 cases (44%) who had moderately positive outcomes in the sense of their own personal reactions, or what they saw happen to their child, did provide substantiating comments to support their judgments. (All phone interviewers were asked to fill out a form assessing various dimensions of communication on the basis of which the reliability of the phone interview could be judged. Overwhelmingly the data was considered to be adequately reliable). Comparing the category I and category II-III outcomes, we note that 85% of the category I respondents (all the phone interview respondents were mothers) reported positive outcomes and 75% of the category II-III mothers felt they had positive outcomes. Thus both our "unsuccessful" and "successful" groups reported satisfaction well above the "two-thirds of people who get well anyway" argument of critics of psychotherapy (See Dr. Frank's [6] recent reexamination of this and other issues pertinent to "The Bewildering World of Psychotherapy".)

It is interesting to note that the two cases judged to be

unsuccessful on follow-up reported great gain, and this with some enthusiasm.

We will now consider the conditions leading to certain therapeutic results being considered very positive by the client, while these same clients were judged to have had only neutral or even negative outcomes by the therapist. We reviewed these cases in comparison with the descriptions of the ICS experience of clients judged very successful by the therapists, but whose follow-up protocols led another judge (a trained clinician) to categorize them as having had negative, or at best moderate outcomes. Comparison of these protocols suggested an interesting dynamic operative in clinicians.

Some of the clients established relationships in which they readily and openly acknowledged their gratitude, the dependence and the high value they placed on the support given to them, particularly by the therapists, and sometimes also by the group of mothers with whom they worked. Many of these cases had entered into ongoing therapeutic relationships. However, on the basis of the follow-up protocols no substantial change in either the mother's personality or the child's originally presented problem had actually taken place. Rather, the client seemed to be saying "I need you" and was willing openly to share "material" revealing this need. It appears that this eager relating and offering of problems influenced the therapists into believing these clients were making good use of the ICS.

It is important to underline the probable fact that many of these mothers (and other of the cases judged on the basis of follow-up to have positive outcomes might have indeed have gotten something of substantial value from the service which helped to accept their dilemmas, problems and anxieties as their own. With some of these families we felt signigicant preventative work was accomplished. Thus, there were a few cases where parents strong needs to defend against their own inadequacy led to an intense need to use externalizing defenses, attributing exaggerated pathology to their child. Often this was seen to happen even where the child described appeared to be essentially normal. Given group support, some interpretive understanding, a better working relationship with the spouse, and the offering of further services as needed, some of these mothers began to separate their needs from the pressures they experienced in relation to the child. Indeed these young children often did generate "normal" pressures as they went through developmental phases involving temper tantrums, nightmares, "no" saying, some picky eating, etc. It appeared that the service helped the parents (mothers particularly) step back, exempt their child from the pathological role and rather accept their own frustrations, impatience or fatigue as legitimate and their own. This left the child free to experience the phase he was in and then "flow on" in what the follow-up revealed to be a

pattern of normal development.

Feeling potentially competent and able to help, seeing a comprehensible principle rather than being overwhelmed by what was initially perceived to be incomprehensible, helped a mother see herself as a resource even if initially she was bothered or puzzled by the child's behavior. Parents sense of confidence was bolstered, and they could go on, not being too bothered and work with the problems their children had, especially when a better working relationship with the spouse had occurred, and sometimes because a good feeling now existed about being related to a service (remembered as potentially available when needed, or actually still being used). The conclusion that a child may indeed remain mildly symptomatic, or be in a phase where his behavior makes him difficult to live with, without the child or parents requiring therapeutic work, supports the similar conclusion reached in our previous follow-up study of the effects of brief service in our out-patient clinic. Here the families initially sought service, concerned about problems with older children or adolescents. (Byars, et al, 1972). This conclusion is also in line with Frank's (1972) recent comments on the role of "demoralization" as a determinant of the need for professional help.

As we continue with the Infant Consultation Service, information from our research fed back to the training staff, and to the participants who are asked to judge their own work as it proceeds, promises to refine our judgment about the need for and the timing for offering further service. Certainly as

viewed in the perspective of this first sample of research data, we can say that the Infant Consultation Service can, in brief span, exert a constructive direct effect on some families; that relevant case finding (52% of our cases went on to additional service) does occur when working with families of very young children, thus supporting our hope that the ICS can provide early intervention which might well prevent later more serious problems; and that there is a possibility that clinicians has a bias to perceive as resistance the readiness of some clients to leave the service after a brief exposure, when the clients themselves can point to substantial positive outcomes they experienced in their brief contact.

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